FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045753

Facility Name: Litchfield HealthCare Center

Address: 1285 East Union Avenue (Number) Litchfield (City) 62056 (Zip Code)

County: Montgomery

Telephone Number: (217) 324-3996 **Fax #** (217) 324-6032

IDPA ID Number: 38-2795206

Date of Initial License for Current Owners: 02/19/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sherry DeBons **Telephone Number:** (281) 579-5022

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Linda Holtzscheiter
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) N/A
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,190	609	5,767	7,566	8
9	SNF/PED					9
10	ICF	15,996	5,725	31	21,752	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,186	6,334	5,798	29,318	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.30%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 01/01/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 01/01/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,190

Medicare Intermediary AdminStar Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	142,189	13,413	8,586	164,188		164,188		164,188			1
2	Food Purchase		128,847		128,847		128,847	(3,585)	125,262			2
3	Housekeeping	81,143	8,228		89,371		89,371		89,371			3
4	Laundry	47,555	10,531		58,086		58,086		58,086			4
5	Heat and Other Utilities			114,721	114,721		114,721	20	114,741			5
6	Maintenance	29,541	31,264	8,360	69,165		69,165	56	69,221			6
7	Other (specify):* Waste/ garbage -See Pg 3.1			16,335	16,335		16,335		16,335			7
8	TOTAL General Services	300,428	192,283	148,002	640,713		640,713	(3,509)	637,204			8
	B. Health Care and Programs											
9	Medical Director			8,250	8,250		8,250		8,250			9
10	Nursing and Medical Records	1,115,820	85,411	22,531	1,223,762		1,223,762	12,566	1,236,328			10
10a	Therapy	162,751	9,321	1,973	174,045		174,045		174,045			10a
11	Activities	34,683	1,550	2,022	38,255		38,255		38,255			11
12	Social Services	21,708		2,013	23,721		23,721		23,721			12
13	Nurse Aide Training											13
14	Program Transportation	5,828		17,860	23,688		23,688		23,688			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,340,790	96,282	54,649	1,491,721		1,491,721	12,566	1,504,287			16
	C. General Administration											
17	Administrative	69,453			69,453		69,453		69,453			17
18	Directors Fees											18
19	Professional Services			488	488		488	4,931	5,419			19
20	Dues, Fees, Subscriptions & Promotions			15,453	15,453		15,453	(4,404)	11,049			20
21	Clerical & General Office Expenses	107,402	8,467	10,409	126,278		126,278	97,403	223,681			21
22	Employee Benefits & Payroll Taxes			351,056	351,056		351,056		351,056			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,616	14,616		14,616	8,661	23,277			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			92,406	92,406		92,406	(18,602)	73,804			26
27	Other (specify):*											27
28	TOTAL General Administration	176,855	8,467	484,428	669,750		669,750	87,989	757,739			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,818,073	297,032	687,079	2,802,184		2,802,184	97,046	2,899,230			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Litchfield HealthCare Center #0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,788	24,788		24,788	47,557	72,345			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(633)	(633)		(633)	633				32
33	Real Estate Taxes			59,264	59,264		59,264	231	59,495			33
34	Rent-Facility & Grounds			123,722	123,722		123,722	1,539	125,261			34
35	Rent-Equipment & Vehicles							3,504	3,504			35
36	Other (specify):* See Pg 4.1			209,757	209,757		209,757	(201,877)	7,880			36
37	**TOTAL Ownership**			416,898	416,898		416,898	(148,413)	268,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,106		118,106		118,106		118,106			39
40	Barber and Beauty Shops			9,419	9,419		9,419	(9,419)	0			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):* See Pg 4.1			20,867	20,867		20,867		20,867			43
44	**TOTAL Special Cost Centers**		118,106	97,629	215,735		215,735	(9,419)	206,316			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,818,073	415,138	1,201,606	3,434,817		3,434,817	(60,786)	3,374,031			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,585)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	633	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	33,016	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,823)	20		28
29	Other-Attach Schedule	(237,590)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (210,349)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	149,563		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 149,563		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (60,786)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Litchfield HealthCare Center

ID# 0045753

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (1,996)	21	1
2	Small Balance Adjustments	0	21	2
3	Memorium/ Benevolance	0	21	3
4	Depreciation Reconciliation	37,766	30	4
5	Activities Program Receipts	0	11	5
6	Depreciation Reconciliation	9,791	30	6
7	Professional Liability Insurance	(18,972)	26	7
8	Barber & Beauty	(9,419)	40	8
9	Public Relation Expense	0	20	9
10	Non Allowable Advertising	(461)	20	10
11	Entertainment	(99)	24	11
12	Fresh Start	(209,757)	36	12
13	Civic dues	(1,789)	20	13
14	Penalities	0	21	14
15	Vending Reciepts	(1,309)	21	15
16	Misc Reciepts	0	21	16
17	Marketing Wages	(33,524)	21	17
18	Maketing Bonus	(4,396)	21	18
19	Marketing Holiday	(769)	21	19
20	Marketing Sick	(702)	21	20
21	Marketing Vacation	(1,954)	21	21
22	Marketing Overtime	0	21	22
23	Legal Fees -Bankrupcty	0	21	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(237,590)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,585)	0	0	0	0	0	0	0	0	0	0	(3,585)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	20	0	0	0	0	0	0	0	0	0	20	5
6	Maintenance	0	56	0	0	0	0	0	0	0	0	0	56	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,585)	76	0	0	0	0	0	0	0	0	0	(3,509)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	12,566	0	0	0	0	0	0	0	0	0	12,566	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	12,566	0	0	0	0	0	0	0	0	0	12,566	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,931	0	0	0	0	0	0	0	0	0	4,931	19
20	Fees, Subscriptions & Promotions	(5,073)	669	0	0	0	0	0	0	0	0	0	(4,404)	20
21	Clerical & General Office Expenses	(11,634)	109,037	0	0	0	0	0	0	0	0	0	97,403	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(99)	8,760	0	0	0	0	0	0	0	0	0	8,661	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(18,972)	370	0	0	0	0	0	0	0	0	0	(18,602)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(35,778)	123,767	0	0	0	0	0	0	0	0	0	87,989	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,363)	136,409	0	0	0	0	0	0	0	0	0	97,046	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	47,557	0	0	0	0	0	0	0	0	0	0	47,557	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	633	0	0	0	0	0	0	0	0	0	0	633	32
33	Real Estate Taxes	0	231	0	0	0	0	0	0	0	0	0	231	33
34	Rent-Facility & Grounds	0	1,539	0	0	0	0	0	0	0	0	0	1,539	34
35	Rent-Equipment & Vehicles	0	3,504	0	0	0	0	0	0	0	0	0	3,504	35
36	Other (specify):*	(209,757)	7,880	0	0	0	0	0	0	0	0	0	(201,877)	36
37	**TOTAL Ownership**	(161,567)	13,154	0	0	0	0	0	0	0	0	0	(148,413)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(9,419)	0	0	0	0	0	0	0	0	0	0	(9,419)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(9,419)	0	0	0	0	0	0	0	0	0	0	(9,419)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(210,349)	149,563	0	0	0	0	0	0	0	0	0	(60,786)	45

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attached page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 20	$ 20	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	56	56	2
3	V	19	Professional Services		Mariner Health Care	100.00%	4,931	4,931	3
4	V	20	Fees, Subscription, Promotions		Mariner Health Care	100.00%	669	669	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	12,566	12,566	5
6	V	21	Clerial & General Office Exp		Mariner Health Care	100.00%	109,037	109,037	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	8,760	8,760	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	217	217	8
9	V	36	Depreciation		Mariner Health Care	100.00%	7,880	7,880	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	231	231	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	3,504	3,504	11
12	V	34	Lease Expense		Mariner Health Care	100.00%	1,539	1,539	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	153	153	13
14	Total			$			$ 149,563	$ * 149,563	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 192	$		$ 20	1
2	6	Repair & Maintenance				556			56	2
3	19	Professional Services				50,336			4,931	3
4	20	Fees, Subscription, Promotions				6,593			669	4
5	10	Nursing & Medical Records				675,703			12,566	5
6	21	Clerial & General Office Exp				527,522			109,037	6
7	24	Travel & Seminar				84,515			8,760	7
8	26	Insurance Premium				2,427			217	8
9	36	Depreciation				81,021			7,880	9
10	33	Taxes - Property				2,346			231	10
11	35	Rental & Leasing				35,937			3,504	11
12	34	Lease Expense				15,801			1,539	12
13	26	Property Insurance				1,581			153	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,530	$		$ 149,563	25

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	61,734	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,945	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,789)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	62,053	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	59,264	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	52,824	8
	1998	55,504	9
	1999	48,854	10
	2000	59,331	11
	2001	58,945	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Line 1 adjusted or not equal to prior C/R due to intercompany entries.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Litchfield HealthCare Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0045753

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE 281-579-5022 FAX #: 281-578-4779

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-100-598-05	PT W 1/2 SW Lands Corp Limits	$ 2,814.08	$ 2,814.08
2.	11-100-598-00	PT W 1/2 SW Lands Corp Limits	$ 56,131.06	$ 56,131.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,945.14	$ 58,945.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,189 B. General Construction Type: Exterior Masonary Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [x] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/a			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Inprovement			1976	192		20			192	9
10	Building Inprovement			1980	870		20			870	10
11	Building Inprovement			1982	2,131	91	20	91		2,131	11
12	Building Inprovement			1983	2,986	149	20	149		2,953	12
13	Building Inprovement			1984	53,393	2,670	20	2,670		49,528	13
14	Building Inprovement			1985	55,378	2,771	20	2,771		49,297	14
15	Building Inprovement			1986	2,920	146	20	146		2,402	15
16	Building Inprovement			1989	5,059	253	20	253		3,245	16
17	Building Inprovement			1990	3,677	184	20	184		2,218	17
18	Building Inprovement			1991	3,100	155	20	155		1,849	18
19	Building Inprovement			1992	10,816	541	20	541		5,736	19
20	See Attached Schedule - Page 12.1			1993	14,559	728	20	728		17,583	20
21	See Attached Schedule - Page 12.2			1994	94,548	2,429	20	2,429		20,963	21
22	Windows			1996	599	30	20	30		181	22
23	Rooftop A/C Unit			1996	8,850	443	20	443		2,713	23
24	Painting			1996	5,000	250	20	250		1,642	24
25	Air Conditioner			1997	3,416	171	20	171		936	25
26	Fire Alarm System			1997	732	37	20	37		193	26
27	Ground Sign			1997	2,900	145	20	145		830	27
28	Paving /Sidewalks Repair			1998	950	63	15	63		311	28
29	HVAC			1998	10,764	538	20	538		2,645	29
30	HVAC - Condensor Replacement Unit			1998	4,275	285	15	285		1,211	30
31	Capet			1998	6,276	1,255	5	1,255		5,539	31
32	Landscaping			1998	6,222	622	20	622		2,765	32
33	Handicap Ramp			1998	950	48	20	48		226	33
34	Fire Alarm System			1999	6,809	681	10	681		2,724	34
35	Replc. 2 AO Smith Water			1999	12,500	1,250	10	1,250		4,792	35
36	6: Isandaire A/C Heaters			1999	6,267	1,253	5	1,253		4,178	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Condensor & Coil Rpr W/N Freezer	2000	$ 3,800	$ 253	15	$ 253	$	$ 823	37
38	Elec Transfer Switch Instld	2000	2,675	268	10	268		893	38
39	F/A Smoke Detection Inspect	2000	782	78	10	78		208	39
40	2: Islandaire Heat/Cool Units	2000	2,168	217	10	217		615	40
41	Architect Serv. F/A Systems	2000	16,988	1,699	10	1,699		4,247	41
42	10: 12 BTU HVAC Units	2000	11,038	736	15	736		1,778	42
43	Architect Fees, FA System	2000	8,612	861	10	861		2,009	43
44	Wter Heater - Laundry	2000	5,400	540	10	540		1,170	44
45	Arch Retainage & Reimbursement	2000	5,238	524	10	524		1,135	45
46	Rplc Fire Alarm System App No.1	2000	85,313	8,531	10	8,531		18,484	46
47	Rplc Fire Alarm System App No. 2	2000	45,074	4,507	10	4,507		9,765	47
48	Arch Fee, Reimburse, 11%	2001	3,379	338	10	338		704	48
49	Constr fee, Fire alarm, App #3 (2.5%)	2001	3,343	334	10	334		697	49
50	7: Islandaire HVAC Units	2001	7,140	476	15	476		912	50
51	Use Tax -7 : Islandiare HVAC Units	2001	446	30	15	30		57	51
52	R Concrete, Employee Entrance	2001	1,520	101	15	101		160	52
53	R Concrete, N. Emergency Entrance	2001	1,635	109	15	109		173	53
54	Rprs Roof & Gutters, Pat Rm	2001	3,649	365	10	365		487	54
55	Nurse Call System Ungrade	2001	4,350	435	10	435		508	55
56									56
57	Service, Nurse Call system	2002	830	97	10	97		97	57
58	Domestic W/H Investigation	2002	2,100	280	10	280		280	58
59	Architect fees - Blue Prints	2002	900	55	15	55		55	59
60	2: Fire Rated Exit Device	2002	6,753	394	10	394		394	60
61	Rplc Doors & frames	2002	16,358	636	15	636		636	61
62	Floor Prep Base Tile work	2002	15,246	678	15	678		678	62
63	Plumbing / Kitchen	2002	5,627	188	20	188		188	63
64	Rprs Wall & Door - Kitchen	2002	9,664	430	15	430		430	64
65	Electrical Work -Kitchen	2002	1,063	35	20	35		35	65
66	Ext Reclamation / Concrete Patch	2002	2,194	98	15	98		98	66
67	Horns & Strobes Instl - F/A System	2002	2,850	166	10	166		166	67
68	HVAC RTU - 2nd floor Hall N Station	2002	6,695	186	15	186		186	68
69									69
70	TOTAL (lines 4 thru 69)		$ 608,968	$ 40,832		$ 40,832	$	$ 237,919	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 608,968	$ 40,832		$ 40,832	$	$ 237,919	1
2	HVAC RTU 1st Floor TV Roon	2002	7,102	197	15	197		197	2
3	Architect Fees / Convent Beds	2002	6,230	173		173		173	3
4	Arch Fee Pat Rm Wardrobes	2002	387	4		4		4	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 622,687	$ 41,207		$ 41,207	$	$ 238,293	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 155,367	$ 15,986	$ 15,986	$	var	$ 93,117	71
72	Current Year Purchases	27,135	15,152	15,152		var	15,152	72
73	Fully Depreciated Assets	316,879					316,879	73
74								74
75	TOTALS	$ 499,381	$ 31,138	$ 31,138	$		$ 425,148	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,122,067	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,345	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,345	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 663,441	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 1996	$ 1,166	$ 59	$ 362	86
87	O/H Allocation 1997	2,262	113	607	87
88					88
89					89
90					90
91	TOTALS	$ 3,428	$ 172	$ 969	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nationwide Health Properties -(Merger to) Omega Healthcare Partners, L.P. as of Sept 27,1991

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	123	07/01/89	$ 123,722	10	40	3
4	Additions							4
5								5
6								6
7	TOTAL		123		$ 123,722 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/89
Ending 06/01/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 5,420 Description: Dishwasher, copier & postage machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Activities & Medical	2001 Ford X E-350 Super	$ 826.50	$ 0	17
18	Transport	Van			18
19					19
20					20
21	TOTAL		$ 826.50	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Litchfield HealthCare Center STATE OF ILLINOIS # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2033	hrs	$ 349,664		$	$ 0	2,033	$ 349,664	1
2	Licensed Speech and Language Development Therapist	10a	259	hrs	8,291			0	259	8,291	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	2017	hrs	86,843			428	2,017	87,271	4
5	Physician Care			visits							5
6	Dental Care	39		visits	0						6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts	0			111,942		111,942	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 444,798		$	$ 112,370	4,309	$ 557,168	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,500	$	1
2	Cash-Patient Deposits	110,550		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	406,365		3
4	Supply Inventory (priced at)	12,126		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 530,541	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	80,167		15
16	Equipment, at Historical Cost	33,818		16
17	Accumulated Depreciation (book methods)	(6,589)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1	(858,650)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (751,254)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (220,713)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,632	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,601		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,651		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,053		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schd 17.1	61,373		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 259,310	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached Schd 17.1	(171,244)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (171,244)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 88,066	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (308,779)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (220,713)	$	48

*(See instructions.)

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (965,522)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (965,522)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	227,621	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 227,621	17
	B. Transfers (Itemize):		
18	**Fresh Start Acctg Due to Bankrupty**	517,189	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 517,189	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (220,713)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,060,484	1
2	Discounts and Allowances for all Levels	(1,372,197)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,688,287	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	488,452	6
7	Oxygen	22,010	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 510,462	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,851	13
14	Non-Patient Meals	5,857	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	179,253	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	175,608	19
20	Radiology and X-Ray		20
21	Other Medical Services	90,038	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 462,607	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Receipts	1,309	28
28a	Miscellanceous Receipts	(227)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,082	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,662,438	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	640,713	31
32	Health Care	1,491,721	32
33	General Administration	669,750	33
	B. Capital Expense		
34	Ownership	416,898	34
	C. Ancillary Expense		
35	Special Cost Centers	148,392	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,434,817	40
41	**Income before Income Taxes (line 30 minus line 40)****	227,621	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 227,621	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,917	2,056	$ 48,676	$ 23.68	1
2	Assistant Director of Nursing	1,421	1,524	27,478	18.03	2
3	Registered Nurses	3,930	4,215	74,294	17.63	3
4	Licensed Practical Nurses	18,636	19,990	326,522	16.33	4
5	Nurse Aides & Orderlies	55,456	59,483	596,808	10.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,299	4,642	121,929	26.27	7
8	Rehab/Therapy Aides	1,927	2,081	40,822	19.62	8
9	Activity Director	1,914	2,050	18,789	9.17	9
10	Activity Assistants	2,123	2,273	15,895	6.99	10
11	Social Service Workers	2,191	2,419	21,708	8.97	11
12	Dietician					12
13	Food Service Supervisor	1,909	2,043	27,031	13.23	13
14	Head Cook	5,839	6,250	54,613	8.74	14
15	Cook Helpers/Assistants	7,970	8,530	60,545	7.10	15
16	Dishwashers					16
17	Maintenance Workers	2,588	2,700	29,541	10.94	17
18	Housekeepers	9,496	10,152	81,143	7.99	18
19	Laundry	5,670	6,239	47,555	7.62	19
20	Administrator	1,989	2,144	74,868	34.92	20
21	Assistant Administrator					21
22	Other Administrative	1,920	2,070	33,070	15.98	22
23	Office Manager					23
24	Clerical	2,218	2,391	27,572	11.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,833	1,983	20,563	10.37	31
32	Other Health Ca MCare Coord/ Ca	1,244	1,292	21,479	16.62	32
33	Other(specify) Mkting & Transpo	2,233	2,675	47,172	17.63	33
34	TOTAL (lines 1 - 33)	138,723	149,202	$ 1,818,073 *	$ 12.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	161	$ 6,344	1 - 3	35
36	Medical Director	19	8,250	9 - 3	36
37	Medical Records Consultant	10	477	10-03	37
38	Nurse Consultant	276	12,566	10-07	38
39	Pharmacist Consultant	151	6,480	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,184	11 - 3	44
45	Social Service Consultant	36	2,184	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	689	$ 38,485		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary F. Buffington	Adminsrtator	100	$ 69,453
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 69,453

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Legal Fees	$ 488
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 488

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,363
Unemployment Compensation Insurance	42,666
FICA Taxes	132,029
Employee Health Insurance	114,487
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension/Retirement	1,642
Insurance Life	2,747
Other Benefits	3,124
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 351,056

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	584
Health Care Worker Background Check	
(Indicate # of checks performed)	3,240
Other Licenses Fees	1,033
Dues	6,672
Civic dues	(1,789)
Home Office Allocation	669
Total Advertising	3,924
Less: Public Relations Expense	(0)
Non-allowable advertising	(461)
Yellow page advertising	(2,823)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,049

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,261
In-State Travel	10,698
Home Office Allocation	8,760
Seminar Expense	2,657
Rounding	1
Entertainment Expense	(99)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,278

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $5,799.60**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,499** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,343**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,585**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Facility Name & ID Number Litchfield HealthCare Center # 0037689 **Ending:** 12/31/2002

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	12,435
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service <> Default <> Physical Plant	3,900
	16,335

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

Meals - adjustment

29,318	Days (Total Patient days)
3	Mult (3 meals a day)
87954	Sub total
2517	meals to employess (reported by facility)
90471	Add Sub
128,847	Divide -Pg 3, line 2, column 2
1.42	Cost per meal

1.42	Cost per day
2517	mult - meal to employees
3,585	= adjust for pg 2, line 2, column2

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	209,757
Home Office - Depreciation	7,880
	217,637

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Supplies <> Default <> Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Contract Svcs - Chgbl <> Default <> Laboratory	20,867
Contract Svcs - Chgbl <> Default <> X/Ray	0
Professional Services Chgble <> Default <> X/Ray	0
Professional Services Chgble <> General / Other <> X/Ray	0
	20,867

Related Illinois Nursing Homes as of 12/31/2002

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	Dixon HealthCare Center	0040865
	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HeathCare Center	0037689
	Montebello HeathCare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HeathCare Center	0039503
	Parkway HealthCare Center	0040857
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

Line 9

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Difference	
Reconcile with schedule XV, line 9:	0
Difference	0

Line 23

OTHER NON-CURRENT ASSETS:	
Asset Clearing <> Default-Prod <> Default-Dept	-
Asset Clearing <> Default <> Realty	-
Asset Clearing <> Capital Expenditures <> Realty	-
Asset Clearing <> Fresh Start Valuation <> Realty	-
Asset Clearing <> PS AM Capital Expenditures <>FS Realty	-
Asset Clearing <> FAS 121 Impairment Valuation <> Realty	-
Other Assets <> Rfndable Deposits-Int Bearing <> Default	-
Excess Reorganized Value <>Excess Reorg Value <> Default	(858,650)
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	-
Total	(858,650)
Difference	
Reconcile with schedule XV, line 23:	(858,650)
Difference	-

Line 36

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	(1,662)
Accruals - Insurance <> Self Funded Ins Accr <> Default	(54,754)
Accruals - Insurance <> Basic Life <> Default	(734)
Accruals - Insurance <> Lt Dsblty <> Default	(150)
Accruals - Insurance <> Executive Supp Life <> Default	(124)
Accruals - Insurance <> Short Term Disability <> Default	(307)
Accruals - Insurance <> Dependent Life <> Default-Dept	(33)
Accruals - Insurance <> Accidental Death Dismemberment <> Defa	(6)
Accruals - Insurance <> NES Insurance <> Default-Dept	(3,603)
Total	(61,373)
Difference	
Reconcile with schedule XV, line 36:	(61,373)
Difference	0

Line 43

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	(171,244)
Total	(171,244)
Difference	
Reconcile with schedule XV, line 43:	(171,244)
Difference	0

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	(1,309)

	Total	-1309	Difference
Reconcile with schedule XVII, line 28:		(1,309)	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	(71)
Personal Purchase Expense <> Default <> Patient Personal Purchase	298
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-

	Total	227	Difference
Reconcile with schedule XVII, line 28a:		227	(0)